Transcript:

Ohio's Current Drug Overdose Prevention and Harm Reduction Efforts

Presenter: Sierra Dantzler
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PRESENTER: Welcome, everyone. Going to give you a moment or two to get settled, and we will begin the webinar shortly.

ANN: Good morning, everyone, and welcome to our webinar, the Overdose Disparity Series. Today's webinar is Ohio's Current Drug Overdose Prevention and Harm Reduction Efforts. It is presented by Sierra Dantzler. It is brought to you by the Great Lakes PTTC and SAMHSA. The Great Lakes PTTC is funded under one of the following cooperative agreements. This presentation was prepared under the Great Lakes PTTC and the opinions expressed in this webinar are the views of the speakers and do not necessarily reflect the official position of the Department of Health and Human Services or SAMHSA.

The use of affirming language inspires hope. Language matters. Words have power, and people first. The PTTC Network uses affirming language to promote the application of evidence-based and culturally-informed practices.

We want to thank you again for joining us. Just a couple housekeeping details-- if you have any technical issues, please individually message either Kristina Spannbauer or Stephanie Behlman in the chat section found at the bottom of your screen, and they will be happy to assist you. During the presentation, if you have any questions for the speaker, please put them in the Q&A section also located at the bottom of the screen, and we'll respond to them following the presentation.

You will be directed to a link at the end of the presentation to a very short survey. We would really appreciate it if you could fill it out. It takes about three minutes, and it helps us report to SAMHSA how people are using our educational series. We are recording this webinar, and it will be available, along with the slides, on our website. And certificates of attendance will be sent out to all who attend the full session, and they will be sent via email. If you'd like to see what other products we have, both with the Great Lakes ATTC, the Great Lakes MHTTC, or the Great Lakes PTTC, you can follow us on social media.

I'm going to introduce Chuck Klevgaard, who is the prevention manager for the Great Lakes PTTC, and he's going to and present an overview of the series.

CHUCK KLEVGAARD: All right. Thank you, Ann. Good morning, everyone. I am, as Ann mentioned, one of the prevention managers here in the Great Lakes area. I'm excited to tell you about the fact that we're in a deep dive into this issue around disparities in overdose here in region 5. We're going to start today by offering some basic definitions, and I'll give you a snapshot of what we know about overdose and disparities here in the region.

And then we'll begin to look at what's happening around the region. So starting with today, you'll hear from Ohio. And then again, we'll take off December. But you'll again-- in January, we'll take another shot at looking at a couple of other states and seeing what's happening around some of the disparities in their overdose prevention efforts and harm reduction approaches. We'll do that in February. So January 27 and February 3 will be additional opportunities to look at this deeper dive and understanding how we are addressing some of the overdose disparities here in region 5.

I want to kick this off with a couple of basic definitions and understand why to talk about these as you share with your colleagues and have these discussions. Just know that the basic definition is differences in incidences and mortality and burden of disease or other adverse health conditions in special populations. That's a-- National Institute of Health definition is a good place to start.

I think it's important also to give folks some context. So from the very beginning of your own dialogue with colleagues, remember to offer some context with that definition. Again, I like the World Health Organization definition, which talks about those differences in health that are not only unnecessary and avoidable, but in addition might be considered unfair or unjust. I think that that gives us a greater sense of context around the fact that it isn't just about the difference in a number, but in fact about the difference related to community conditions or unfair or unjust circumstances in terms of looking at what's happening.

The other way to help folks understand early on about disparities is that for many of us we talk about it in terms of proportionality. So often disparities are represented as a disproportionate number of health conditions and deaths compared to the general population. So in the graph that's on your screen, looking at the fact that African-Americans make up 13% of the population but represent almost half of all new HIV cases is a way of visually representing a disparity that begins to shed light on why does this matter to focus on disparities.

So in that same way, as we think about definitions and we hear from epidemiologists or researchers, thinking about how disparities are discussed

and measured-- a couple of important things to keep in mind. In some cases, you will see and hear in this series disparities represented in terms of frequencies or accounts or deaths. Or in this case, we might be talking about rates or percentages. Two other contextual factors that are really key-- and you'll hear this again in the series repeatedly, and often-- the folks who work in health or public health or injury prevention will talk about disparities in relation to equity. And that might be a measure of access to care, housing, and neighborhood characteristics.

And finally, we think of disparities, and what's often measured and discussed related to that are social determinants of health. So in terms of demographic factors, determinants that we might think of and might even be presented as drivers or causal factors. So to the more we understand about the number and the issues or conditions that correlate to that number, and then the drivers, the more we can make a strong case where both understanding and presenting a disparity. As you can see again, some of these issues present and shed light on prevention, which I'll say a bit more about before I turn this over to today's presenter.

I want to give you this quick national snapshot. So again, I'm going to share with you some numbers that relate to region 5, what's happened nationally and what's happened here in our region. But want to offer a couple of quick caveats. So I'm talking about some numbers that come from NCHS, from the CDC website and the National Center for Health Statistics. And we just looking at some data briefs in terms of looking at some very quick trend analysis and some very, again, sort of snapshots.

And I use that term because that's what they are. They're just a quick glimpse at something at a moment in time. They don't tell the whole story and they don't shed light on all of the reasons or causes for what we see happening. But they do give us a little bit of context, so that as we get started and you'll hear from Sierra in Ohio in just a few moments, you'll have a sense of what's happening here in region 5 to put some context around that.

The other quick caveat is that this snapshot does not take into account of what happened during the beginning and middle and where we are within COVID-19. So we know that, again, there's been some erosion of progress and momentum that was gained. There is also significant impact on specific populations in disproportionate ways. So in the same way we talk about disparities in disproportionality with regard to mortality and morbidity and overdose death and rates, I think some of the same populations have been hit hardest by COVID. So I'm not going to shed any more light on that, just offer it as a caveat right now.

So the quick snapshot that I want to start us out with is that, again, when we look at comparative analysis between 2017 and 2018, we saw some good news. So in 2018, you see 67,000 drug overdose deaths in the US. And that was a decline in terms of that number of deaths in those two years.

So you can see between 2017 and '18, you saw a 4% decline. We saw the rate change as well. The age-adjusted rate of overdose in 2018 as compared to 2017, we saw things moving in the right direction. So for 14 states and the District of Columbia, that overdose death rate was lower in 2018 than it was in 2017. Here, that important caveat again about COVID changed some of that for many of us here in the Midwest.

So this is what the map looked like, again, with the orange being some states that saw the statistically higher rates, a few of those. And then, again, states that seemed stable-- again, I still see all those gray states as somewhat good news, meaning that there's some indication that this crisis may in fact be plateauing off in a general sense. And then we have some states that are green with that lower rate. Those are the 14 states that I just mentioned that saw a statistically lower rate when comparing 2017 and 2018.

So part of this snapshot-- I want to offer a few more pieces of context. We know that synthetic opioids other than methadone-- drugs such as fentanyl, fentanyl analogs, tramadol-- increased significantly during that same time period. Now, that shed light on-- what we're talking about, driving increases or changes. We've talked about the opioid crisis as waves. And then moving from prescription drugs to heroin to a third and fourth wave being looking at fentanyl, and then drugs that are blended or mixed with fentanyl as being part of what folks might be calling a fourth wave.

So we know that overdose death regarding cocaine and stimulants also saw an increase in recent years. So in spite of the fact that we saw momentum across the population, we see changes with regard to the third and fourth waves. So we know that fentanyl, fentanyl analogs have fueled much of that increase in deaths.

And that's also been disproportional with regard to age and race. So between '15 and '17 in 20,000, we saw changes with regard to race and ethnic groups and all age groups seeing increases in synthetic opioid overdose death rates. So that seems fairly cross-cutting. But we've also saw it get harder with Black and African-American populations in larger central metro areas. We'll spend more time in the series later on talking about differences between urban and rural populations.

But I want to hit at some of what we think of as challenges to prevention And as we frame this, and turn the presentation over-- these are some of the more specific things that we fully acknowledge are making our job harder with regard to dealing with overdose rates and, in particular, preventing those overdose.

So what I mean by negative representation, that first one, has to do with what stereotyping and stigma. To give you an example of Black or African-American populations with substance use disorders are sort of doubly stigmatized, by both their minority status and their substance use disorder. So

negative images of one population in our region may contribute to discrimination in the quality of care and how they treat how they're treated within both medical systems and in clinical or behavioral health settings.

Important to acknowledge the fear of legal consequences playing a different role. Again, proportionality, understanding that historically certain populations experience much more mistrust, not only with health care and social services, but within the justice system. The proportion of folks that are serving sentences or incarcerated currently is disproportional, racially. And we know that that's related to the number of-- and folks of color who are in fact jailed or incarcerated due to with an opioid use disorder or other issues.

We know that what drug you use also can impact how systems treat you. So when you hear folks talk about, in the next several presentations, about how different populations use drugs differently or use different opioids, know that issue of fear of legal consequences interferes significantly at times in being able to do good prevention work. Intergenerational use-- also important. We know that this history of looking at not only one generation using and having some of the same risk factors and social determinants passed on, but they're also using in front of, and in some cases with, family members. So we think that it's important to pay attention to this issue of intergenerational use, polysubstance use, in particular in communities with high poverty and economic disinvestment. Intergenerational and polysubstance use issues make our job harder and make it important to pay attention to those kinds of issues.

And finally, it's a lack of culturally responsive or respectful know. We know that that's even across here in region 5, certainly true of the whole country in terms of how well we deal with culturally responsive care, in terms of both understanding what it means to be culturally responsive with regard to prevention and treatment. Separate and unequal prevention and treatment services-- again, a challenge, whether we've dealt with them separately and whether we give equal treatment to populations has been key.

And finally-- some might think that the more positive side-- some of the good news. So listen over the next several presentations in the series for some of what we know are evidence-based practices to reduce disparities. So a comprehensive holistic approach-- understanding that cultural piece, thinking about working with multisectoral, diverse partnerships-- in some cases, the role of the faith community playing a strong role. How different cultures perceive and understand health care systems and treatment systems in consideration, culturally relevant public awareness-- it's an important piece that generic universal approaches and messaging are rarely successful with specific cultural populations. And some of those at greatest risk-- it's really important to consider very specific, culturally relevant messaging.

So specific kinds of engagement strategies are being employed in region 5. So you're going to hear some very specific ways in which state leaders in

overdose prevention across region 5 have considered very specific, cultural relevant ways to engage specific populations in reaching them. Not only in being able to provide culturally relevant services, but having the engagement strategies be successful and culturally specific engagement strategies.

And finally, culturally relevant and diverse workforce-- the ways in which we think about. Hearing examples repeatedly in our region about how know if a strategy has been to do outreach after a nonfatal overdose, that outreach is far more successful if the person conducting that outreach looks like and is perceived as culturally relevant to that person who's receiving that. Meaning that if this is an African-American in an urban setting and they get a phone call or even a visit after COVID from a white female, we know that we're far less likely to be successful.

So thinking in all the different ways that culturally relevant, diverse workforce plays a significant role as we move forward into this. So without further ado, I want to turn things over at this point back to Ann.

ANN: Thank you, Chuck. That was a great overview. I'm looking forward to the rest of the series.

I just wanted to quickly introduce our speaker today. I'm very excited. Sierra Dantzler is a program manager at the Ohio Department of Mental Health, where she manages the Project DAWN program, the state health department's community naloxone distribution initiative. Sierra coordinates the distribution network to ensure Ohio's most at-risk populations have adequate access to harm reduction resources and wraparound services. Prior to her work at the Ohio Department of Health, Sierra served as the public health analyst for the Appalachian high intensity drug trafficking area as part of the Opioid Response strategy initiative, where she provided technical assistance and guidance to local community organizations to assist them in the implementation of evidence-based overdose response strategies.

As a devoted public health professional, Sierra is passionate about improving the quality of life for all people and believes change starts with compassion, empathy, and altruism. Sierra received her bachelor's degree from the University of California Irvine and her master's degree from the University of Kentucky. We are excited to have you, and welcome, Sierra.

SIERRA DANTZLER: Thank you so much, Ann. And thank you, Chuck, as well. I am so glad to be able to share what's been going on in Ohio and some of the work we've been doing in overdose and harm reduction at the state health department.

I've been in this role since late January. So it's definitely been quite an interesting year thus far, with managing a program that is quickly evolving in addition to navigating challenges relating to the current pandemic. So our

team has definitely learned a lot, which has helped us shift our focus as necessary, especially when trying to address disparities.

So today I will cover what we're currently seeing in Ohio with overdoses, our harm reduction efforts-- mainly syringe service programs and naloxone-- our state coalition action group, the harm reduction campaign, and finally, briefly mention some plans we have for the immediate future. Our violence and injury prevention section has great, great epi and surveillance teams that work very hard to make sure that we are capturing accurate overdose data and completing the analyses that help us understand the impacted populations and make those informed decisions on programs.

So when looking at the trends relating to emergency department visits for overdoses and overdose deaths in Ohio, they tend to closely mimic each other, which can be helpful for us and local programs to anticipate a surge and try to be a bit more prepared. Earlier this month, ODH released the 2019 drug overdose death reports, and the graphs you'll see in the next few slides from that report. But there are some pretty interesting findings. Ohio has seen a decrease in overdose death rate in 2018, which is pretty much the same as the rest of the country, as Chuck mentioned earlier. But that rate's increased again in 2019.

Since we know fentanyl usually drives overdoses in Ohio and a lot of other regions-- mainly because it's often mixed with other substances-- a theory behind the decrease is that maybe fentanyl wasn't as present in 2018 like it was in 2017, especially carfentanil, at least for Ohio. But there's still no real way of knowing what exactly happened. But I'll talk a bit more about certain substances in the next slide.

And as I mentioned, fentanyl tends to drive our overdoses, and it accounted for 76% of deaths last year. Other substances that have been on our radar are cocaine and cyclostimulants, which in this case include methamphetamine. And so deaths related to stimulants had the largest increase last year.

When looking at age, you can see the 35 to 44 age group have the highest rate of unintentional overdose deaths. And that group has usually had the most-- or almost the same rate as the 25 to 34 age group. But in 2019, there is a bit more of a distinction between the two rates. So while fentanyl was mostly involved in deaths among all ages, the percentage of fentanyl-involved deaths decreased as age increased, which is interesting because it makes us ask questions about the relationships between age and behavior, or preference, when looking at substance use.

Now, looking at race and ethnicity, Black non-Hispanic males continue to have the highest overdose death rate, which has been the case since 2017. And the rates are much greater than the state average. Historically, Black non-Hispanic females have had the lowest rate, and data is now showing an

increase among that demographic that is almost the same as white females last year. So it's another thing we want to closely monitor. Because if we're seeing a trend change for the worse, it's something we definitely want to address sooner rather than later.

And as it was for age, most overdose deaths among all race and ethnicities involve fentanyl. It's not pictured here, but the demographic report for this last year-- 2019's drug overdose report-- highlighted drug combinations. And the fentanyl and cocaine combo were quite high for Black non-Hispanic males and females. And when looking at age and ethnicity together, the data shows that the 35 to 44 age group has the highest overdose death rate among all demographic groups shown here, except for Black males, who had the highest overdose death rate in the 55 to 64 age group.

So now we'll get into the first of one of our many efforts on how Ohio Department of Health addresses overdoses, which is naloxone. There are a number of Ohio policies that have made naloxone access and distribution possible for laypersons in the state. But I just wanted to highlight a couple of the big ones, starting with House Bill 4, which allows take-home naloxone program staff or pharmacists to dispense naloxone legally. This is what allows naloxone to be available without a prescription as long as the protocol is authorized by a physician.

And more recently passed this September was House Bill 341, which were basically amendments to the naloxone laws. This bill does expand civil liability for laypersons, as well as expands access to naloxone. So it also makes it less of a barrier for take-home naloxone programs to operate legally by removing a requirement to hold a terminal distributor license, which can often be expensive to renew annually, especially if you're not a local health department.

It will also allow medical professionals other than physicians, like APRNs and physician assistants, to authorize protocols for individuals to personally furnish naloxone, which is another challenge for certain take-home programs that aren't based in local health departments, for example, and don't really have the adequate access or relationships with physicians that are willing to authorize the protocol. And I do want to mention that Ohio does have a good Samaritan law that provides criminal immunity for people who seek or obtain medical assistance for an overdose.

So project DAWN-- which stands for Deaths Avoided With Naloxone-- is Ohio Department of Health's network of take-home naloxone distribution programs. And this program was named in honor of Leslie Dawn Cooper, who was a 34-year-old Ohio woman who struggled with addiction for years before passing away from a witnessed overdose back in 2009. The first Project DAWN program was actually established in Leslie's hometown of Portsmouth back in 2012 through a grant from Ohio Department of Health, and ODH still supports these programs by providing them with free naloxone kits using state funds.

But Project DAWN programs are actually also funded by local and other government funding resources.

How the network of Project DAWN programs operate today is just a little different. What started off as a few programs in the early years has exploded to over 85 agencies that operate a whopping collective of 230 distribution sites that cover 67 of the 88 counties in Ohio. In the past, programs were required to be open to the public. But as the nature of naloxone distribution has evolved, that requirement has been removed, which definitely allows programs to reach those critical populations, like justice-involved individuals and those in active treatment.

Last summer, we implemented a registration process in order for programs to receive naloxone that is funded by Ohio Department of Health. And the reason for this is really an attempt to systemize a network a bit more, strengthen our connection with the programs, maintain accountability and being able to consistently collect data, especially when it comes to funding programs through grants like the integrated naloxone grant, which I'll get into in a moment.

But naloxone is expensive, especially when purchased on such a large scale that we do. And we really need to be able to manage that. And programs typically do distribute within their own county or city, but it's not a requirement of Project DAWN, actually. Programs can operate in any region within Ohio. And some even provide statewide service, which is very helpful for people who live in an area without a Project DAWN, like some of our rural counties.

Most of our Project DAWN programs are comprised of entities like health departments, recovery boards, treatment facilities, health systems, and harm reduction programs and organizations. And as we've implemented the grant-- the integrated naloxone grant-- other types of lead agencies have registered, which has been extremely, really good to see. But the typical distribution mechanisms through Project DAWN include brick-and-mortar places like a health department. But often training and distribution occurs during community outreach and events, mobile coaches, quick response teams going to the home of someone who recently experienced an overdose, and correctional facilities like county jails or community corrections.

And this slide is just to give an idea of what type of kit we supply to programs. It's basically a pouch with a Project DAWN logo, two doses of Narcan, gloves, and a face shield. Some programs prefer to order only the Narcan only, so they can put together their own kit, which sometimes includes things like their own branded training materials and resources, fentanyl test strips-- which we don't currently fund, but are still extremely useful. So we're really hoping we can start funding them soon.

And as I previously mentioned, the programs do have reporting requirements in the form of a monthly log and intake forms. Now, the monthly log contains

aggregate data for number of kits that have been distributed for every month throughout the year, and it also contains data pertaining to the number of people that were trained or educated and the number of purported overdose reversals. The log also gives us an idea of how many kits are going out into the community. I will say that the reported reversals number is often underreported, as that information is usually taken from the intake form when someone returns it back to a Project DAWN program for a refill and indicates that they use their kit for an overdose.

And the naloxone intake form is completed for every person that receives a kit. So it's individual level data. The form doesn't ask for any personal health information, but it does ask demographic based questions, like how they identify themselves in terms of ethnicity and gender, as well as their experience with or history with intravenous drug use.

And like I previously mentioned, we also ask why they're getting a kit or if it's their first time receiving a kit. We do say it's voluntary, because we never want this form to be a barrier for someone getting naloxone. And sometimes people just don't want to answer questions, and that's totally fine. We do have a section for the program to submit some required information, which at least captures the number of kits that person received and the distribution setting.

So this form really helps us at the state level look at who is getting a kit and how they got a kit, meaning which mechanism we're setting, as opposed to the monthly log that merely tells us when and how much. We are always looking at ways to improve the intake form to not only capture better data, but to basically make sure we are using inclusive and culturally sensitive language. And our local programs have always been really good about helping us determine the necessary changes with that.

So the integrated naloxone grant-- last July, we rolled out the first cycle of the integrated naloxone access and infrastructure grant, which was done in partnership with what I call our sister agency, the Ohio Mental Health and Addiction Services. They are actually the-- sorry. They are the actual recipients of the state opiate response funding, so we partner with them to address some of the activities in the prevention portion of that grant, since we are the agency that houses the naloxone program.

And so we developed this funding opportunity for new and existing Project DAWN programs to basically implement, expand, and strengthen access to naloxone. And we really wanted them to focus on innovative strategies integrating naloxone into existing services, because we want to make sure that naloxone is getting into the target population and people who need it most, so reaching people at those critical points of access.

In addition to that, we did learn previously that many Project DAWNs appreciated the naloxone-- free naloxone-- but they still had trouble with infrastructure and staffing to really implement those necessary strategies. So

this funding was to help support and develop that infrastructure that is very necessary to operate these programs. We do require for grantees to evaluate one component of their program in depth, which can range anywhere from the efficacy of training to how well one distribution strategy compares to others.

Also, all grantees are required to develop an outreach plan to raise awareness about their program and recruit participants within target demographics, focusing on health equity and outreach to underserved populations. So we also ask their outreach to include targeted awareness strategies for racial and ethnic minorities who may not be aware of the extent of the opioid epidemic in their communities. And we also ask that they not only focus on people who use opioids, but also people who use non-opioid drugs such as cocaine or methamphetamine, since we know those substances, again, are often cut or contaminated with fentanyl. And the last thing we ask that they engage in meaningful collaborations with other community based organizations.

So in the first cycle of the grant that started last July, we funded about 38 programs. And we just started the second cycle at the end of September with SOR 2.0. We are now funding 42 Project DAWN programs. And as a result of this funding, we've seen some pretty cool partnerships and distribution mechanisms, like the development of online mail-order systems for naloxone, EMS leave-behind programs, peer volunteer networks, partnerships with churches and other faith-based organizations, court systems, and domestic violence and human trafficking survivor organizations. And these partnerships actually really came in handy and proved to be resourceful when COVID hit.

And earlier this year when COVID did hit, the state and local public health orders really limited programs from operating as normal with in-person trainings and distributions for a while. So most programs had to scale back, temporarily suspend operations, or just modify their program to continue distribution, but in a way that limited contact, of course. And since this was something that was completely unprecedented, people were kind of wondering, well, what the heck? What do we do now? How do we do this? So it also made us really shift our focus, because we understand that these programs should still be a priority. And as many people who use these services are considered high risk, and we don't want there to be a gap in services.

A lot of the Project DAWN programs were health department, so staff staffing pulled into COVID activities really stretched people thin and made it difficult. So MHAS-- that sister agency I previously mentioned-- and ODH released guidance for all these programs and also partnered with Harm Reduction Ohio, which is one of our Project DAWN programs that happens to be the largest program to distribute naloxone via an online mail ordering system statewide. So we wanted to make sure that people still had a way to receive naloxone anywhere in the state if their nearby program didn't have the capacity or ability to serve them.

And some interesting modifications came as a result of COVID. At first, there were maybe only a few or a handful of online ordering programs. But now there are almost 20. And at the state level, we also focused on getting naloxone known to people being released from county jails as the sheriffs were trying to decrease the capacity in those facilities by rapid release.

Some of the programs shifted to virtual training via Facebook or some other online mechanism. Some programs were offering drive-up or drive-through services, where people don't even have to get out of their car but they still engaged in training and the intake process by wearing a mask. Some programs did treat outreach in areas where there was an overdose spike, or also known as hotspots.

But I will say one of the most important modifications that we saw were helpful and resourceful were the programs leveraging the existing partnerships with other agencies and community organizations. An example of this-- at Ohio State University, Wexner Medical Center mainly operated their Project DAWN out of their hospital system. Since people really weren't going to the hospital much for overdoses during COVID, they noticed that they are missing key populations to distribute kits. So they moved from the hospital system and engaged in community outreach by partnering with other programs that were already doing it in this area. And so that way, they were able to reach much more people and get naloxone into the hands of those that needed it.

And for those who were in the IN grant, we did ask those subrecipients to create a contingency plan for when something like this does happen again. Hopefully, it doesn't. But that way if it does, they have a plan of action and can continue services. And also, we added an option for programs to order kits that included a face mask to help slow the spread of the virus, which was really helpful for kits going to people who were displaced or in homeless shelters.

So the data. In 2019, we saw that programs distributed more than 47,000 kits, and naloxone was used to reverse over 8,700 overdoses. But so far this year, Project DAWN programs have distributed more than 73,000 kits and reported over 14,000 overdose reversals. And again, I just want to mention that number of overdose reversals is likely underreported.

But I will say that I expected an increase in kit distribution this year, but not nearly this much, especially due to the limitations brought on by COVID. So it makes me extremely happy to work with people who are innovative and committed to saving lives despite the many challenges. And we do have amazing people operating these programs.

So when we look at who is getting a kit, we see that kits are mostly going to white non-Hispanics, and this information is based on what's reported on the naloxone intake forms. But you notice there's 15% of people chose not to

identify their race or ethnicity. And like I said, sometimes people just don't want to answer the questions.

But even if everyone within that 15% chose an ethnicity other than white, it would still paint the picture that minority populations aren't receiving the service as much as white people are, which means we still have a lot of work to do to figure out why that is. Is it access? Is it stigma related? I'm sure it's a combination of many things, as these issues are never simple, but they are rather multifaceted. It's still something we should examine further.

And here we see that most kits are going to people in urban areas, which isn't entirely a surprise, considering that according to OSU's Office of Urban Engagement, over 50% of Ohio's residents live in 10 of the 88 counties, which definitely helps put things into perspective. But still, if we want to reach more people in rural areas, we have to examine how programs are marketed, promoted, and how they're delivered, and really learn which approaches work and don't work.

And finally, how? In which distribution settings are people mostly getting these kits from? And so we see that most distribution occurs in the community, via online mail order systems and syringe service program settings. There are limitations to this data. For one, programs often report incorrect setting categories.

So for example, the jail prison setting is apparently very low. But when we took a closer look at the setting categorized as other-- because they can fill in what other means-- programs have indicated mechanisms or settings that would actually fall under jails. And so that actually lets us know that we need to go back and revise our intake form to make these setting selections a bit more clear.

Another limitation is that programs are not required to report and take information for kits that are not funded by ODH, which means we're probably not seeing all activity within certain settings. So these are what I call topical analysis that are very basic, but we do have plans to look at the Project DAWN data in depth for a more comprehensive evaluation in the near future.

So now we'll get into the syringe service programs. In Ohio, the language is actually bloodborne pathogen prevention program, but I will mostly just say syringe service because it's definitely less of a mouthful. So legislation was passed back in 2015 that basically legalized syringe programs, but at the approval of a local board of health. Luckily, the law allows these boards to contract with private non-profits, which provides a lot of flexibility and takes the pressure off those local boards in terms of staff capacity.

As of now, there are only 23 known syringe service programs in Ohio. And recently the state budget started including harm reduction funds in the amount of $50,000 specifically for syringe programs. But these funds can only go to

local health departments directly, and each agency can only receive up to $15,000. We actually allocated $30,000 for a mini-grant-- which I'll get into later-- and the remaining $20,000 was allocated to 14 active programs to help them purchase overdose surge materials, including sterile syringes during COVID.

Unfortunately, the state health department doesn't have a program for three service projects in the same manner as our Project DAWN program. But some of our other prevention grants have syringe service programs as the setting for comprehensive systems. And some others are funded through grants within the HIV section at our agency.

So another major prevention effort in our violence and injury prevention section is the Drug Overdose Prevention grants. And these grants are under the Overdose Data to Action funding from CDC. It's an effort to provide increased resources to high burden counties and to meet the complex needs of those at-risk populations, and it's also an effort to align the state and local prevention strategies.

ODH funds 21 counties for comprehensive drug overdose prevention through multiple grant programs. Some of these grant activities include fostering community partnerships through community coalitions and strategic planning, convening overdose fatality reviews, developing community response plans for the response to spikes and overdoses, and the development of comprehensive and sustainable systems. Goodness.

The agencies that engage in the comprehensive and sustainable systems implement policies, support systems, and environmental changes. And they link at-risk individuals to clinical and support in community settings and strategies. And some of those strategies include health care, which means FQHCs, hospitals court systems, job and family services, and those harm reduction strategies like syringe service programs, and naloxone. Also QRT follow-up after hospital discharge, screening protocols, other rapid response for inmates on release-- there's a lot of strategies that are within these grant efforts.

So next, I'll discuss the work that's being done with them Ohio Overdose Prevention Network, or Ohio OPN. So Ohio OPN is actually an action group of the Ohio Injury Prevention Partnership, which is the state coalition that ODH oversees. And the purpose of the Ohio OPN is to identify and implement actions for the prevention of drug abuse and overdose. And this network is really a collective of stakeholders from all over the state from diverse fields that collaborate to develop state-level guidance and recommendations for local programs to apply and increase their capacity for overdose response.

The network is divided into four subcommittees, which are data, harm reduction, pain management, and policy. There is a strategic plan that guides

all of our activities within each subcommittee. I'm actually going to single out harm reduction, because it's the largest subcommittee in the network.

And this subcommittee is one of the ways we are able to maintain or remain connected to the syringe service programs and naloxone programs and build relationships with them. We want to make sure that we can provide guidance and technical assistance for the implementation and operation of such programs, since there are more syringe programs being developed and there will be additional grant opportunities for them as well.

We're also looking at standardizing the data, because we've learned that all programs collect different data elements, which makes it a bit difficult to evaluate overall program efficacy at the state level. And we are always exploring new models and ways to increase naloxone access, as well as researching methods of program sustainability and funding diversity. This year, we did put out a survey to Ohio Sheriffs Association about naloxone in jails and that helped us-- we were able to really gauge the uptake of harm reduction strategy like naloxone within the jail setting.

Also, a strategy is to educate high-risk individuals on harm reduction practices. So this group has also been helping promote Ohio Department of Health's awareness campaign, which we call OH Against OD. And I'll cover that in a minute. But in spring of this year, during COVID, we quickly put out a mini-grant for syringe services programs utilizing in the state harm reduction funding that I mentioned earlier. We were able to award two programs the maximum amount of $15,000, which did enable them to resume and strengthen their services.

So I mentioned a minute ago ODH has been working on an awareness campaign, OH Against OD. And it was developed to increase awareness about naloxone access, harm reduction, and fentanyl in the drug supply. We are currently finalizing some components to launch a comprehensive website that will have education and resources materials available for reference and download.

But in the meantime, however, we've been able to develop what we call prep materials that have been shared with our grantees and local programs for them to co-brand and promote their services. And the ad shown here-- it's just one of the many as we have available for programs to use. We have the tag about fentanyl and cocaine, the call to action, like carrying naloxone, never be alone, and call 911.

We worked with one of our vendors to place environmental ads all over the state. So here are some examples shown. You see bathroom stalls, gas pumps, bar coasters, convenience stores-- they're in a myriad of places all over the state. And it was actually really cool to see this come to life, especially as I myself came across while I was out getting gas.

So next steps-- we do have some ideas on how to improve our programs and better address disparities we're seeing, starting with the recommendations from Ohio Minority Health Strike Force. In May, they released a report, which is called a blueprint, that provides recommendations to both eliminating racial and ethnic disparities in COVID-19 and other health outcomes and improve overall well-being for communities of color. There were a total of 34 recommendations. And they were categorized into health care, socioeconomic environment, physical environment, and data, implementation, and accountability.

So using information in the violence and injury prevention section, we are still reviewing and working through these recommendations. But some of the things we've already started working towards include the expansion of our OH Against OD campaign to make sure that we are targeting minority populations that are disproportionately impacted by overdose deaths and making sure we develop additional messaging that is also culturally sensitive. We also want to strengthen our connection to syringe programs utilizing SOR funds, since it wouldn't limit us to local health departments, and it would actually be enough to create a formal grant opportunity, since syringe programs are another critical point of access for many populations.

And lastly, we want to make sure our grant programs are utilizing the Place Matters instrument, which is a tool from our Office of Health Equity that helps the state monitor where grant activities are actually occurring using information from census tracks. And that's what's been going on in Ohio. This is my contact information if you want to reach out. I believe all this information will be shared.

But I'm going to open up for questions and comments. And even suggestions-- we'll always welcome discussions that will help us improve our efforts. So I'd love any feedback if you guys have it.

ANN: Thank you very much, Sierra. This is all really great information. And we do have one question. Someone said, how do you implement the drive-through or the drive-up naloxone training?

SIERRA DANTZLER: So this is from one of our local health departments that-- I don't know exactly what the logistics were in terms of where people go to drive up, but I guess it depends on the actual structure of that facility. People drive up in their cars. I'm assuming they would call ahead, to my knowledge. And the drug overdose prevention coordinator for that agency will go up to the car, do the naloxone intake information, provide some education-- at a distance training.

Everyone's wearing masks. They have a little binder full of information. And they have some naloxone kits in a little pouch for them. They give it to them, and they drive off. It's very simple and quick and limits contact.

ANN: Great. Thank you. I would welcome anyone else who has questions to either put them in the Q&A section or the chat, and also invite Chuck, if he has any follow-up about information in the next webinar, if he wants to share that.

CHUCK KLEVGAARD: A couple thoughts for Sierra and some questions. This is Chuck again. I see woven throughout your presentation, Sierra, lots of evidence, that you're using some of those evidence-based practices all over the place-- everything from diverse partnerships to culturally relevant approaches in messaging, all kinds of really exciting ways in which I see evidence-based practice in all of your approaches.

One of the questions I was-- as you spoke-- was interested in is the idea of FQHCs in terms of, what's your sense? I saw that one of your slides, if that is a sense of where you're doing some of the work through. Can you say a bit more about FQHCs and the role that they play in the state with regard to, first of all, dealing with and serving underserved populations? But also what's the potential of FQHCs, do you think, for folks who are trying to reach populations that are hard to reach?

SIERRA DANTZLER: So with the FQHCs, it's under one of our drug overdose prevention grants that I don't manage. But I do know that the role they're mainly playing is linking people to services, like primary health care treatment, other basic human resources. They serve as a pass through when someone goes to a facility for any other service. They do a comprehensive evaluation of that person, and will refer them to any other necessary services.

I can refer you to Hilary Stoll, who manages that program. She can give you a bit more insight into other roles that they may play in reaching those populations and helping with implementing the health equity portion of our goal.

CHUCK KLEVGAARD: Cool.

ANN: All right. Thank you, Chuck. It looks as though we have answered all of the-- oh. Spoke too soon. Are there any efforts or plans to develop any youth-oriented, under-18 opioid meth prevention materials that focus on rural in Ohio?

SIERRA DANTZLER: Yes. That is a very good question. We do have a team that works with youth. So we are going to be collaborating with them in developing a bit more age-appropriate materials and programs surrounding that. That's something we're still exploring and how to best execute that. But it's definitely on our radar to look at and implement those strategies as well, focusing on that population.

ANN: Great. Thank you. We have another question that I am on the OHCHC, the state FQHC association. FQHCs provide a tremendous amount of direct

comprehensive services, including MAT and OUD. So if people had questions, they would be happy to talk with them.

SIERRA DANTZLER: Awesome. That's great. Thank you.

ANN: Just double checking to see. It looks like we don't-- of course, I said this last time. We don't have any additional questions.

Again, you have Sierra's contact information. This webinar will be available on the Great Lakes PTTC website in the products section. If you have any other specific questions, you can get a hold of either Sierra or Chuck Klevgaard or the Great Lakes PTTC, and we will be happy to assist you.

And I would like to thank everyone for their time. We were able to get through this webinar quickly, because all of the information was amazing. And Sierra did such a great job. So we will end a little bit early. And I again would like to thank Sierra and Chuck and all of you for your time today.

SIERRA DANTZLER: Thank you.

CHUCK KLEVGAARD: It was great. Thank you, Ann. I also want to remind folks-- hope you'll join us for the next part in the series. I think that this opportunity is both exciting and unique in some ways that for part of the audience that's listening today, you may have worked in harm reduction for years and know that harm reduction has not always been part of mainstream public health or treatment or counseling or prevention, and often seen as a separate way of approaching this work.

The fact that it's so integrated here in region 5 is exciting. The fact that we have this kind of a series and that we have harm reduction highly flown as a really important, prominent way of dealing with the issue is also exciting. My two cents on how exciting it is to finally see harm reduction as considered best practice and evidence-based practice and in the mainstream and integrated with state approaches.

So thank you all for joining as well. I want to also, in addition to Ann, say thank you for joining. And we'll look for you in January on the 27th, and then again in February on the 3rd.

ANN: Thanks, everyone. Have a good day. Thanks.

SIERRA DANTZLER: Bye, everybody.